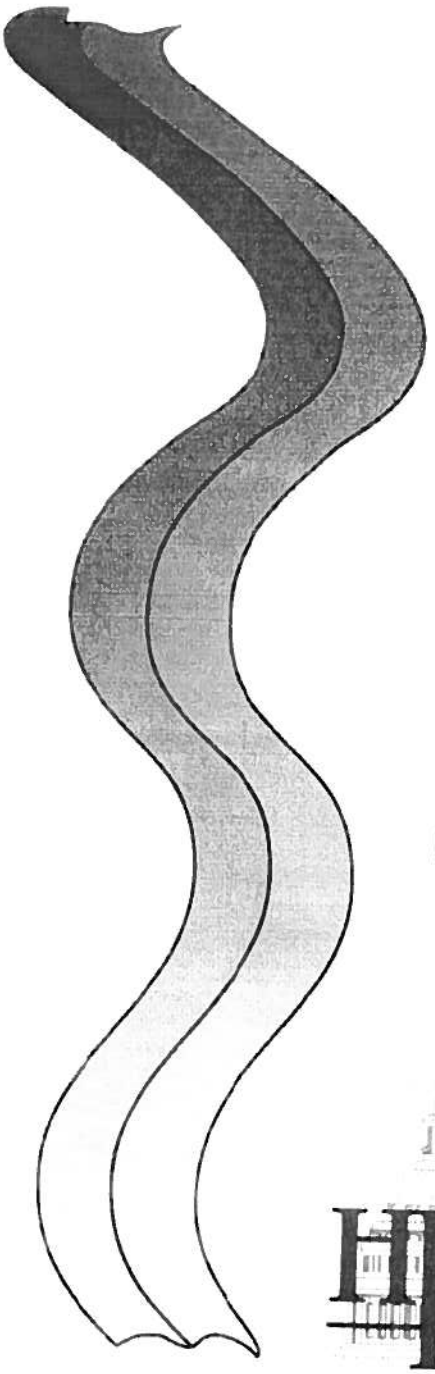
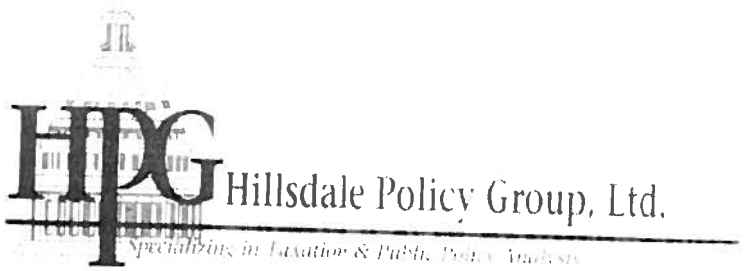


BCBSM Medigap Subsidies: Unintended Consequences

Gary Wolfram, Ph.D.
January 2012



BCBSM Medigap Subsidies: Unintended Consequences

Gary Wolfram, Ph.D.
January 2012

Executive Summary

When Act 350 of 1980 was passed, Section 609 allowed Blue Cross Blue Shield of Michigan (BCBSM) to use up to one percent of its earned subscription income to subsidize the Medigap policy premiums of senior citizens. However, since the rates that BCBSM are able to set must be approved by the Commissioner of the Office of Financial and Insurance Regulation (OFIR), the amount of this subsidy to seniors who qualify for Medicare is effectively determined not by BCBSM, but rather by the Commissioner. In the past, the Commissioner has chosen to regulate the rates of BCBSM in such a way that the subsidy has been at the maximum, effectively one percent of the BCBSM revenue.

While this legislation may have been well intended, it has unintended consequences that result in increased costs on other sectors of the insurance market, in particular small businesses, with a resulting drag on Michigan's economy. Any amount of BCBSM earned subscription income that must be used to subsidize the Medigap coverage of senior citizens cannot be used to lower the premium of the small business owner who is providing health insurance for her employees, or the person who has lost his job and must seek out individual coverage, or any of the other policyholders of BCBSM. In effect Michigan small business, which is facing difficulties in trying economic times, has been subsidizing Medigap coverage for all manner of retirees.

The subsidy for seniors is ill-targeted since it has been available to seniors who have higher incomes and who may not even live in Michigan. Although the Commissioner has recently allowed BCBSM to provide subsidies based upon certain factors, such as Michigan residency, the amount of subsidy and which seniors qualify must be re-determined with every rate request. The subsidy can easily work in the opposite direction—making it more difficult for those of low income to obtain health insurance—because BCBSM revenue is diverted to subsidizing seniors.

In addition, even if keeping premiums low for people because they are old enough to qualify for Medicare made sense, there is no need to require BCBSM to provide a subsidy. A quick internet search will reveal that there are several Medicare plans offered by competing insurers that have lower premiums than those offered by BCBSM even after the required subsidy.

In addition, we should be clear that the subsidy is for coverage beyond what Medicare covers. Medicare covers 80% of approved expenses, so seniors who do not purchase Medigap coverage at all are not left without insurance. Medicare recipients may also obtain Medicare Advantage plans that provide basic Medicare coverage and additional services. These plans were not available when Section 609 was enacted. Nor was Medicare Part D, the prescription drug plan, available. Given the changes in Medicare over the past fifteen years, the required subsidy to senior citizens is not only ill-targeted by unwarranted.

Rather than requiring the subsidization of Medigap coverage of senior citizens who may have higher incomes and lesser need for subsidy than individuals or small businesses, the Legislature and OFIR Commissioner should allow the board of directors of BCBSM to decide how to serve its mission as a non-profit provider of health insurance in Michigan. This will result in lower premiums for individual and small business and a stronger Michigan economy.

I. Background Introduction

A. Blue Cross Blue Shield of Michigan[1]

The thirty-nine companies that currently comprise the Blue Cross Blue Shield Association have their origins in a teacher-based system of pre-paid hospitalization organized by the President of Baylor University, Justin Kimball, in 1929. In response to the inability of teachers and others to pay for hospital care and financial problems at Baylor University's hospital, Kimball devised a program whereby teachers would be guaranteed 21 days of hospital care per year at the University hospital and a discount on the other days in return for a monthly payment of 50 cents. This plan was adopted by the teachers and other employer groups around Dallas. Soon the concept spread throughout the country under the Blue Cross symbol. Blue Cross was a plan whereby an association would contract with hospitals to accept patients for hospitalization and would contract with subscribers to receive a monthly payment. The goal was to stabilize hospital revenues and provide the ability of subscribers to obtain hospital care.

During the Great Depression the hospitals found themselves in financial difficulty as patients could not afford hospital care. The Blue Cross plans were able to reduce the problems associated with this by providing a stable source of funds to hospitals and guaranteed access for patients. However, these plans created a legal problem. Were these associations insurance companies and thus subject to asset and reserve requirements that bound insurance companies under state law? If so, then they would not be viable since the associations did not have the required amounts of capital to start up and the hospitals were generally non-profit entities that weren't interested in becoming a mutual or stock company.

Rather than imposing the same solvency standards that applied to insurance companies, New York enacted legislation in 1935 that allowed for the creation of health service associations outside of the insurance law. The boards of the companies were to be made up of representatives of the hospitals, and the rates were subject to regulation by the insurance commissioner. The success of the New York statue led other states to follow suit.

In 1938, the Michigan Hospital Association led the drive to enact Michigan's first statute allowing the formation of a Blue Cross association in Michigan, the Michigan Hospital Service. Two enabling acts were passed in 1939, one to allow the formation of an association for prepaid hospital care and one for prepaid physician care as a mechanism for providing a flow of funds to

---

[1] [1]For a history of Blue Cross and Blue Shield nationally and in Michigan see S. Payton and R. Owsner, "Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate of Need," *Michigan Law Review*, Vol. 79, December 1980, pp. 203-277, and R. Cunningham III and R. Cunningham, Jr., *The Blues: A History of the Blue Cross and Blue Shield System*, (De Kalb: Northern Illinois Press, 1997)

medical service providers and keeping medical care costs reasonable.[2] These acts required the Michigan Hospital Service to be a non-profit organization. The program was so successful that by 1941, after enrolling the employees of the automobile companies, Michigan had the second largest association in the United States

In 1974 the Legislature enacted legislation that allowed for the consolidation of Blue Cross (hospital) and Blue Shield (physician) corporations and altered the composition of the boards in response to the political conditions of the time. In 1980, the Legislature passed PA 350 which among other things substantially altered the composition of the board of BCBSM to shift control towards the subscribers.

The end result of this legislative history is that BCBSM is a non-profit corporation that is regulated by its own statute, PA 350 of 1980, rather than being regulated under the Insurance Code[3] as are other insurance companies.

B. Medigap[4]

Medicare is the federal government health insurance program that covers persons who are 65 years old and over and those under 65 with certain disabilities and those with permanent kidney failure. Medicare Part A helps cover in-patient hospital care, skilled nursing care, hospice, and some home health care. Medicare Part B helps cover doctor's services, out-patient hospital care, and some home health care. It also covers many preventative services. Medicare Part D is a prescription drug option that is run by Medicare-approved private insurance companies.

Medicare Advantage Plans, also called Medicare Part C, are health care plans run by Medicare-approved private insurance companies. These plans include Medicare Part A and B and usually other coverage such as Part D, sometimes for an extra premium cost.

A Medigap policy, also known as Medicare Supplemental Insurance, is a policy provided by private health insurance companies that will pay certain costs that Medicare doesn't cover. These would include copayments, coinsurance and deductibles. This is different from a Medicare Advantage Plan in that Medicare Advantage is a way of obtaining Medicare benefits along with other benefits, whereas a Medigap policy is a policy separate from the Medicare policy.

Medigap policies follow state and federal laws. In most states, including Michigan, Medigap policies are standardized along several levels. Each company that offers a particular level of Medigap policy must offer the same benefits. In some states, insurance companies may offer a lower cost Medigap Select plan that requires you to use doctors and hospitals within its network.

---

[2] 1939 PA 108 and 109.
[3] 1956 PA 218.
[4] For a more detailed description of Medigap see, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, 2011, Center for Medicare and Medicaid Services and National Association of Insurance Commissioners

Persons who purchase a Medigap policy must be enrolled in Medicare Parts A and B and pay the Medicare Part B premium. Medigap policies sold after January 1, 2006 do not offer prescription drug coverage. This coverage is offered under Medicare Part D.

II. The Current Issue

Section 609(5) of The Nonprofit Health Care Corporation Reform Act, the act under which BCBSM is regulated, contains the following provision:

"Except for identified cost transfers, each line of business over time must be self-sustaining. However, there may be cost transfers for the benefit of senior citizens, and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation."

This language would appear to allow BCBSM to offer a subsidized rate for the Medigap coverage it offers its senior citizen subscribers. However, under PA 350, the rates set by BCBSM must be approved by the Commissioner of the Office of Financial and Insurance Regulation (OFIR). As a consequence, while BCBSM might decide not to offer subsidies for its Medigap coverage or offer subsidies of less than the maximum allowed under statute, the rulings of the Commissioner have resulted in BCBSM being required to provide the maximum subsidy.[5]

BCBSM, making the point that the subsidy was particularly ill-targeted in that seniors received the subsidy regardless of income, whether or not their employer already subsidized their premiums, and even if they no longer lived in Michigan, obtained a Final Decision from the Commissioner in December of 2009 that Act 350 does not require that all senior citizens have equal access to the Medigap subsidy "irrespective of income."[6] In June of 2010, the Commissioner ruled that BCBSM need not provide the subsidy to individuals who were receiving benefits under a group health plan, and could deny the subsidy to subscribers who are no longer residents of Michigan.[7]

In August of 2010, BCBSM filed proposed rate increases for Medigap subscribers in line with eliminating the subsidy for those seniors who are covered under a group health plan or are not Michigan residents. The Commissioner deemed the filings complete on December 22, 2010. On March 8, 2011, Charles Austin filed a request for an evidentiary hearing, and he was joined by the Attorney General on March 24. Eventually the parties stipulated to the elimination of the Medigap subsidy for out-of-state subscribers beginning August 1, 2011. However, BCBSM found it necessary to drop its request to relate subsidies to the income of subscribers and to deny subsidies to subscribers whose Medigap premiums are subsidized by a current or former employer. This can result in some small businesses effectively paying higher premiums in order to subsidize the Medigap policies that would have been paid for by large employers. BCBSM retained the right to bring these issues up in a future filing.

---

[5] Cite AG newsletter on last year's denial of Medigap rate increase
[6] Office of Financial and Insurance Regulation, Case No. 09-746-BC, December 7, 2009.
[7] Office of Financial and Insurance Regulation, Order No. 10-048-BC, June 30, 2010

III. Ill-Effects of Requiring a Medigap Subsidy

Since BCBSM is a non-profit corporation that was established in order to provide access to health insurance for the citizens of Michigan it may seem reasonable that in return for its non-profit status BCBSM should use any revenue it has over costs to reduce rates, and therefore the provision of Section 609(5) makes sense.

Unfortunately, while the Legislature may have been well-intentioned when it allowed for a subsidized premium for seniors purchasing Medigap coverage from BCBSM, the actual result has been a negative for the Michigan economy and is not an effective means of providing access to health insurance. Instead, the Medigap subsidy creates unintended consequences that move in opposition to providing access to health insurance, particularly for the employees of Michigan small business employers and those who purchase in the individual market. There are several reasons for this as outlined below.

A. Unintended Granting of Control over the Subsidy to OFIR and Convolution of Rate Process

As noted in Section II, BCBSM does not have control over the amount of subsidy it may wish to give to its Medigap policy holders, as its rates must be approved by the Commissioner of OFIR. So what appeared to be language which allowed BCSM to decide if its surplus would best be used to reduce rates for seniors rather than lowering rates for all its customers, turned out to grant the Commissioner the ability to provide below-market insurance premiums for a particular group.

The description in Section II of the current issue demonstrates how convoluted the procedure has become. BCBSM came to the perfectly reasonable conclusion that it makes little sense to subsidize the rates of seniors whose Medigap premiums are already subsidized by their employers or who do not live in Michigan. It has taken several filings, hearings, orders and intervention of the Attorney General over the course of more than a year to arrive at the position that BCBSM may in the future ask for the ability to deny or reduce the subsidy of these seniors. It was only after this lengthy process that BCBSM was even granted the ability to deny seniors who live in another state a Medigap subsidy.

B. Medigap Subsidy is Ill-Targeted

It may make some sense for BCBSM to use some of its revenue to reduce premiums for lower-income individuals. Granting a subsidy for seniors does not accomplish this. As BCBSM pointed out in its earlier rate filings, granting Medigap subsidies to all seniors will result in reducing premiums for senior whose income may exceed that of the average Michigan individual. In addition, there are seniors whose employer or former employer provides health insurance benefits that already subsidize their Medigap premiums.

One can imagine a 66 year old executive at a major corporation who is making $300,000 per year and whose company is paying for his Medigap premiums. Under the current allowable rate filings, BCBSM must use part of its earned subscription income to reduce the Medigap premiums for this senior.

Does it make sense to require BCBSM to reduce premiums for a retired couple, each of whom receives $45,000 per year in pension income, while a single mother of three children earning $30,000 per year pays an unsubsidized rate? Michigan would be better served if rather than the Legislature giving the Commissioner of OFIR authority to decide how much one particular interest group will be subsidized, BCBSM would be allowed the ability to use its revenue as the board of directors of BCBSM sees fit to reduce rates on low income individuals or small businesses that provide health benefits to their employees.

C. Politicization of Rate Process

By setting into statute subsidization of rates for a particular interest group, the Legislature has invited the politicization of the rate-making process. First, senior citizen groups and their associated lobbying organizations, have a strong incentive to convince those in the executive branch to grant them the maximum subsidy allowed by the statute. Second, other special interest groups have an incentive to get the Legislature to enact statutes to require BCBSM to give them subsidies as well. The end result is a rate process not based upon efficient use of resources, but on the political division of BCBSM's revenue.

D. Increased Rates for Small Business and Individual Coverage

As shown in Table 1, over the past five years BCBSM has had to use annually about $200 million of its revenue to subsidize Medigap premiums. To provide perspective, $200 million is equivalent to health insurance coverage for 22,250 employees of small businesses in Michigan.[8]

Table 1
Medigap Subsidy in Millions of Dollars

Year	Medigap Subsidy Amount
2006	200.9
2007	202.3
2008	181.0
2009	186.4
2010	198.4

Source: BCBSM, The Medigap Subsidy: A Rising Burden on Michigan Job Providers

The Commissioner of OFIR has noted that, "The legislature recognized that the availability of resources to fund health care services was not unlimited."[9] This means that every dollar of revenue that is used to fund Medigap subsidies cannot be used to reduce premiums for small

[8] Source: Small Business Association of Michigan.
[9] Office of Financial and Insurance Regulation, Case No. 09-746-BC

business owners. As a consequence employer-based health insurance premiums are higher than they would otherwise be.

Rising health insurance premiums are a major concern of Michigan's small business. The average cost for BCBSM coverage for Small Business of Michigan members has risen steadily over the past five years as shown in Table 2.

Table 2
SBAM average cost per employee for BCBSM coverage

Year	Annual Premium
2007	$7820
2008	$8163
2009	$8330
2010	$8629
2011	$9068

Source: Small Business Association of Michigan

Lowering the cost to employers of purchasing health insurance for their employees would have two effects on employment. The first is that this would lower the cost of producing in Michigan. As a consequence of reduced production costs, existing firms will produce more, and new firms will be attracted to Michigan as it will become relatively less costly to produce in Michigan. This will result in higher Michigan employment, and is known as the output effect. Basically, by reducing the marginal cost of production, firms will supply more and hire more labor.

The second effect is that firms will substitute labor for capital in the production process. Since lowering employer-provided health insurance reduces the cost of hiring labor, the relative price of labor to capital will have fallen, thus inducing firms to use more labor even if they produced the same amount of output. This is known as the substitution effect.[10] Both of these effects will result in greater output in Michigan and increased employment.

Michigan's unemployment rate of 10.9% is exceeded only by California and Nevada.[11] There were 511,000 unemployed persons in Michigan in July 2011.[12] Michigan's real state gross domestic product has declined from $368 billion in 2007 to $345 billion in 2010.[13] Michigan is

[10] For a detailed explanation of the income and substitution effects of a price change, see a typical intermediate microeconomics textbook, for example, Hal Varian, *Intermediate Microeconomics*, 7th edition (New York: Norton,, 2006), Chapter 8.
[11] U.S. Department of Labor, Bureau of Labor and Statistics, Economic News Release, August 19, 2011. Data are for July, 2011,
[12] Michigan Department of Technology, Management and Budget, Office of Labor Market Information.
[13] U.S. Bureau of Economic Analysis, gspo611.xls, Table 1.

the only state in the country to lose population from the 2000 to 2010 census. Clearly its economy could use the boost that would be provided by removing the Medigap subsidy and allowing BCBSM to reduce rates on its employer group plans.

Aside from the effect on employment and production in Michigan, eliminating the required Medigap subsidy would result in greater health care coverage for workers in Michigan. Over the past six years there has been a substantial reduction in the number of businesses with less than 50 employees that are able to offer health insurance coverage to their employees. Table 3 shows that the number of firms offering coverage to less than 50 employees through BCBSM, which has about one-half of this market,[14] has fallen steadily from 222,000 in 2005 to 134,000 in 2010, a decline of nearly 40%.

Table 3
Number of Small Businesses with Health Care Coverage
(1,000s)

Year	Number of Small Businesses
2005	222
2006	213
2007	210
2008	177
2009	150
2010	134

Source: BCBSM, The Medigap Subsidy: A Rising Burden on Michigan Job Providers

While it is possible that some of these employers moved to other carriers, this data is consistent with other data that shows a decline in the number of employers providing insurance for their employees. For example, the total number of member months covered by small employers has fallen from 13.458 million in 2003 to 8.135 million in 2010.[15]

This decline in the number of employer-based health insurance policies results in fewer persons with private health care insurance in the state. This, in turn, puts greater pressure on the Michigan Medicaid budget, as some of these employees will end up in the Medicaid system rather than purchasing individual health care policies.

[14] "The State of Competition in the Small Employer Carrier Health Insurance Market in the State of Michigan," OFIR, June 2011, Figure 1.
[15] "The State of Competition in the Small Employer Carrier Health Insurance Market in the State of Michigan," OFIR, June 2011. Page 7, and "The State of Competition in the Small Employer Carrier Health Insurance Market in the State of Michigan," OFIR, May of 2008, calculations from Figure 1.

IV. Alternatives for Seniors to BCBSM Medigap Coverage

The requirement that BCBSM provide a subsidy for seniors does not even provide a large benefit for seniors. This is because seniors have a wide range of choice of companies that provide Medigap coverage, many of which have lower premiums than the subsidized rate of BCBSM. This is particularly the case for seniors who choose a Medicare Advantage Plan.

As an example, in Kent County alone there are 13 Medicare Advantage policies available that have a lower total premium than the total premium for comparable coverage with Medicare Part B premium, Medicare Part D premium, and BCBSM subsidized Medigap coverage. Eliminating the effective requirement on BCBSM of providing the Medigap subsidy would still leave seniors with options which are at least as attractive.

V. BCBSM Non-Profit Requirement

Some have argued that BCBSM should be required to provide the Medigap subsidy since it has been granted non-profit status and thus is exempt from Michigan's premium tax on insurance companies. There are at least two reasons to put aside this argument, one empirical and one theoretical.

The empirical reason is that the Medigap subsidy far exceeds the tax benefit of BCBSM's non-profit status. Table 1 in Section III above showed the amount of the Medigap subsidy, which has ranged from $181 million to $202 million in the past five years. During that same time period, the tax exemption benefit has ranged from $77.9 million to $88.0 million. It is clear that the Medigap subsidy requirement is far in excess of any tax benefit BCBSM receives as a non-profit.

From a more theoretical perspective, the purpose of non-profit status is to allow a company to pursue goals that go beyond the maximization of profit.[16] For-profit firms are driven to seek profit above other goals because failure to maximize profit will eventually result in stockholders seeking other investments with a collapse in the equity of the company or the replacement of the management of the company.

Non-profit corporations, on the other hand, legally are not owned, but are rather governed. This allows the governing body to pursue the goals of the organization. Non-profits do not exist in order to allow governments to pursue goals through the non-profit. The board of directors of BCBSM should decide the goals of the corporation—not the government. This argues against the Medigap subsidy unless the board of directors of BCBSM decides to offer it in the process of fulfilling the goals of the corporation.

V. Conclusion

The Legislature may have intended to allow BCBSM to choose to provide a subsidy to seniors for its Medigap coverage when it enacted Section 609(5) of Public Act 350, however, the effective result has been that the Commissioner of OFIR determines the subsidy and its amount. The Commissioner has effectively required BCBSM to offer the maximum subsidy set in the

[16] For a discussion of the purpose of non-profit corporations see R. Cooter and T. Ullen, *Law and Economics*, 6th edition (Boston: Addison-Wesley, 2012) pg. 135-138.

statute. This results in higher labor costs, lower employment, less health care coverage for non-seniors, and less total output in Michigan. The subsidy is ill-targeted as wealthy seniors, and up until the most recent rate setting, non-resident seniors receive the subsidy. Given that seniors have a number of other options to obtain the equivalent of Medigap coverage at lower costs, Michigan residents would be better off by eliminating the statutory and regulatory requirement for a Medigap subsidy.

About the Author: The author is President of Hillsdale Policy Group, Ltd, and the William E. Simon Professor of Economics and Public Policy at Hillsdale College. He is the author of *Towards a Free Society: An Introduction to Political Economy* and has published numerous works on public policy issues. He has served in several policy positions, including Michigan's Deputy State Treasurer, member of the Michigan State Board of Education, President of the Board of Trustees of Lake Superior State University and Congressman Nick Smith's Washington Chief-of-Staff. Dr. Wolfram received his Ph.D. in Economics from the University of California at Berkeley and has taught at the University of California at Davis, Mount Holyoke College, Washington State University, and the University of Michigan at Dearborn.

This paper was commissioned by the Small Business Association of Michigan